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Dental Health in the Army Reserves and National Guard-- A Mobilization Problem?

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ABSTRACT

Clinical studies and experience have shown that the dental health status of U.S. Army Reserve and National Guard soldiers is considerably worse than that of active duty soldiers. This information has been known for some time, but it became especially apparent during mobilization for Operation Desert Shield and Storm. A large number of Reserve and Guard soldiers had to have extensive dental work completed to prepare them for deployment to the Persian Gulf. The time these soldiers spent in the dental chair detracted from training and other critical deployment requirements. As a result of the Desert Storm experience, Congress has pressed the Department of Defense to find a solution to the dental health problem in Reserve Component personnel. This paper will examine the extent and the significance of this problem and review possible solutions.

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INTRODUCTION

During mobilization for the Persian Gulf War, the dental health of Army Reserve and National Guard soldiers became a subject of widespread interest. Indeed, at one time or another, this issue commanded the attention of the Chief of Staff of the Army, the Reserve Forces Policy Board, the Assistant Secretary of Defense for Health Affairs, and the United States Congress. In an Army Times article, a National Guard general officer listed dental problems in Guard and Reserve units among the major obstacles they had to overcome while preparing for deployment.¹ This same conclusion was reached by the General Accounting Office (GAO) following an investigation of readiness issues in National Guard roundout brigades. In its report, the GAO concluded that, had they been needed, "...the ability of each of the three brigades to deploy quickly would have been hampered significantly because many soldiers had severe dental ailments."²

The interest in Reserve and National Guard dental health has not waned despite the fact that the war has been over for more than a year and Reserve Component soldiers have long since gone home. Prompted by Congress, officials within the Department of Defense continue to review the matter and to search for solutions before another mobilization is necessary. Some of the solutions under consideration have significant resource implications.

With all this attention, a casual observer might be led to

believe that the dental health of reserve forces must have impeded the Army's ability to field an effective fighting force. Yet, according to information reported by the Army Deputy Chief of Staff for Personnel, only 8 Reserve and National Guard soldiers called up for Operation Desert Shield/Storm could not be deployed because of dental problems.³ More importantly, although several individual soldiers may have experienced prolonged dental processing and treatment time, no units were delayed from deploying to the Persian Gulf for dental reasons.⁴

Does the dental health of personnel in the reserve forces represent a significant problem worthy of the attention it has received, or is this a case where Congressional and military leaders have overreacted? Is a plan to provide dental care for members of the Reserve and National Guard warranted, or would it be an ineffective - and possibly expensive - benefit? This paper will consider those questions by reviewing data collected during the mobilization of reserve forces for Operation Desert Shield/Storm and by examining information from past military operations and dental health studies.

DENTAL HEALTH IN THE RESERVE COMPONENTS

The dental health of Reserve Component personnel suddenly became a subject of keen interest following a visit by the Chief of Staff of the Army to mobilization sites at Fort Polk, Louisiana,

Fort Stewart, Georgia, and Camp Shelby, Mississippi. During his visit, the Chief of Staff observed that many Reserve Component soldiers were spending a considerable amount of their time in the dental chair to correct extensive dental problems. He was particularly concerned because of a perception that the time spent seeking dental care detracted from training requirements.⁵

Anecdotal reports from other mobilization sites seemed to confirm the Chief of Staff's observations. For example, an Army Times article featured the story of a reservist at Fort Campbell, Kentucky, who had to be taken to the operating room to remove several badly decayed teeth.⁶ At other sites, there were stories of Reserve and Guard soldiers whose teeth fell out with the mere touch of a dental instrument, and many who had to have all their teeth removed because of advanced dental decay or periodontal disease.⁷ When similar reports were received by members of Congress, attention to dental health in the reserve forces became a matter of even greater concern.

Official data collected during the mobilization effort provided a more objective picture of the problem. As a routine part of processing for deployment, soldiers were required to have a dental screening examination to determine their level of dental "fitness". This was accomplished in accordance with a standardized Department of Defense (DoD) classification system which defines three levels of dental health for military members:⁸

Class 1 - soldiers who require no dental treatment;

Class 2 - soldiers who have dental problems that, if left untreated, are not expected to result in a dental emergency within 12 months;

Class 3 - soldiers who have dental problems that, if left untreated, are likely to cause a dental emergency within 12 months.

Class 3 is considered to be an unacceptable level of dental health for military members. Studies have shown that dental emergency rates will be almost four times greater for soldiers in dental Class 3 than for those in Class 2, and almost eight times greater than for those in Class 1.⁹

A fourth category (Class 4) is also defined by DoD. This is a temporary administrative classification rather than a level of dental fitness. It is used to identify personnel who require a dental examination - either because they have not been previously examined and classified, or because they have not been examined for a lengthy period of time.

Results accumulated during the dental processing of Army Reserve and National Guard soldiers provided compelling evidence that they did, indeed, have significant dental health problems. A total of 21.9 percent were found to be in dental Class 3. This compared to only 7.8 percent for active duty soldiers. National Guard soldiers were in worse shape than Reserve personnel - 27.2 percent vs. 19.3 percent Class 3, respectively. Moreover, dental health ratings for roundout brigades were worse than the average for other units. Thirty percent of personnel in the 48th Infantry

Brigade (Mechanized) were Class 3, 31 percent were Class 3 in the 155th Armored Brigade, and 36 percent were Class 3 in the 256th Infantry Brigade (Mechanized).¹⁰

The poor ratings for Reserve Component personnel should have come as no surprise to officials in the Army. In 1985, the Army Dental Corps conducted a detailed study which analyzed the dental health of 7,512 Reserve and National Guard soldiers. Results of the study (published in 1986) demonstrated an overall Class 3 rating of 29 percent for Reserve Component personnel. The distribution of Class 3 soldiers was predictive of that seen during mobilization for Desert Shield/Storm. It showed that the National Guard had a higher percentage of Class 3 soldiers (31.7 percent) than the Army Reserve (25.6 percent), and the percentage of Class 3 soldiers in combat arms units was higher than in other types of units (34.5 percent vs. 27.1 percent, respectively).¹¹

The 1985 study also showed that the distribution of Class 3s was disproportionate among pay grades. Thirty-two percent of enlisted soldiers were Class 3, compared to 16 percent for warrant officers and only 9 percent for commissioned officers. Not surprising, the lowest pay grades had the highest percentage of Class 3 soldiers: 46 percent for E-1s and 40 percent for E-2s.¹²

As is the case now, results of the 1985 study stimulated much interest. Senior leaders from both the reserve and active forces pressed the Chief of the Army Dental Corps to find a solution to the problem. Although several possibilities were discussed, the

Army Vice Chief of Staff eventually decided that no special provisions were necessary. An important consideration in this decision was a realization that substantial resources would be required to provide even a minimal level of care. Another important consideration was an implicit understanding that, in the event of mobilization, the Army's dental service could surge to take care of the problem in Reserve and National Guard soldiers.¹³

DENTAL HEALTH AND COMBAT EFFECTIVENESS

Why have senior Army and Defense Department officials taken such an active interest in the dental health of Reserve Component personnel? The answer is simply because any condition which interferes with performance or removes a soldier from his or her unit during training or combat is a legitimate concern. The relationship between dental health and combat effectiveness was summarized by a former Chief of the Army Dental Corps:

Whereas in civilian life poor oral health may only cause discomfort and pain, in the military environment a simple toothache can incapacitate a combat soldier as effectively as a combat wound. ...A soldier lost to duty...decreases the fighting ability of the organization. When large numbers of soldiers are lost to duty for any reason, this reason must be corrected or a significant reduction in overall force effectiveness will result.¹⁴

No data is available on the total number of man-days that have been lost during military operations due to dental emergencies. However, information gleaned from reports during periods of actual

combat and data collected from field training exercises suggest that it has probably been significant. According to these sources, a soldier suffering from a dental problem can expect to be lost to his unit for a period of one to five days.¹⁵ Two characteristic features of combat operations help explain this delay in obtaining dental care: 1) units are often far removed from the nearest treatment facility, and 2) transportation may not be readily available because of requirements to evacuate serious injuries and move critical supplies.

Even with these obstacles, dental emergencies would not be a major concern if they rarely occurred. However, documented reports from past conflicts and from field training exercises indicate that, historically, this has not been the case. Studies conducted during the Vietnam War found that the annual rate for dental emergency visits ranged between 140 and 210 per 1,000 troops.^{16,17} In an investigation of Army personnel participating in prolonged field training exercises, the rate was 167 per 1,000 troops, and dental emergencies comprised 21.5 per cent of the total medical sick call.¹⁸ Another study found that, excluding injuries, dental complaints ranked second only to upper respiratory infections as a cause for lost duty time.¹⁹

This information is particularly disturbing because most dental emergencies can be prevented. In their 1981 study, Payne and Posey judged that 74 percent of the dental problems they

observed during a field training exercise were preventable.²⁰ Other investigators have suggested that up to 67 percent of the dental complaints which result in emergency visits could be prevented if known dental conditions were treated prior to deployment.²¹

EVOLUTION OF DENTAL HEALTH STANDARDS

Certainly, this is not a new problem for the Army. Dental disease has long been recognized as one of the most common afflictions of mankind, and military recruits have not been immune. How did the Army manage this problem in the past when the nation needed to mobilize a large combat force?

American Civil War

Since at least the time of the American Civil War, dental health has been an important consideration in judging fitness for duty. Then, as now, physical examination standards for induction in the Army included an evaluation of the teeth. The rationale for dental induction standards was explained by the Army's Surgeon General, William A. Hammond:

No one can be healthy whose teeth are deficient or in bad condition; soldiers require that these organs should be sound. The loss of the front teeth prevents the soldier from tearing his cartridge and the loss or carious state of the molars seriously interferes with the proper mastication of his food.²²

Unfortunately, after soldiers met these standards and were brought on active duty, their dental health was generally ignored. There were no dentists in the Union army during the Civil War and, early on, little thought was given to providing routine or interceptive care to reduce dental complaints during combat. Military leaders soon came to appreciate the disruptive effects of unchecked dental disease, however. At times, the demand for dental care from troops became so great that commanders had to make special arrangements for civilian dentists to visit the battlefields.²³ According to one report, when General Sherman entered Savannah in 1864 with 100,000 men, he had to employ every dentist in the city to take care of his soldiers' dental complaints.²⁴

World War I

By the time of the first World War, dental requirements for induction into the Army had been modified only slightly. In 1917, Physical Examination Standards No. 1 stated that, to be accepted, recruits "...must have at least four serviceable molar teeth, two above and two below on each side."²⁵ No reference was made to incisor (front) teeth in this order - perhaps because soldiers were no longer required to tear open a cartridge in order to load and fire their weapons.

The physical examination standards for dental health were altered several times during the draft period. In later standards,

the minimum of eight masticating teeth was reduced to six, but these also specified six functional incisor teeth. Toward the end, there was a general tendency to relax the standards even more and to "...let down the bars."²⁶

One reason the Army could afford to relax the induction standards was because a Dental Corps had been established in 1911. Utilizing this new asset, the Army was able to accept soldiers with dental problems and, through a program of interceptive dental care, prepare them for deployment overseas. The Army's dental officers were primarily based at mobilization sites and points of embarkation. According to historical reports, priority for treatment was given to men with focal infections, and a special effort was made to remove all unserviceable teeth.²⁷

The limited resources of the Dental Corps were inadequate to provide all the treatment needed by military recruits, however. Care by Army dentists had to be augmented by civilian providers, some of whom were organized into a voluntary service group - the Preparedness League of American Dentists. During the mobilization period, this organization performed 613,285 gratuitous dental operations on young men scheduled for military service.²⁸

World War II

The period between the two World Wars saw the Army adopt more stringent induction standards for dental health. Mobilization Regulation 1-9, published in August 1940, required potential

recruits to have 12 teeth - "...6 masticating teeth and 6 incisor teeth properly opposed."²⁹ However, as the nation attempted to mobilize sufficient personnel to fight the coming global war, they found the dental requirements to be too restrictive. Of the first two million men drafted for service, 9 percent were rejected for failure to meet the minimum standard, and dental defects constituted the primary reason for physical rejection.³⁰

Officials eventually found it necessary to relax the induction requirements in order to maintain an adequate pool of military manpower. As pointed out by Johnson, if the standard had been maintained, "...by the end of 1943 nearly 1,000,000 men who were [eventually] inducted under the liberalized dental standards would have been lost to the service."³¹ The Army found that it made no practical sense to reject otherwise healthy and qualified applicants on the basis of dental conditions which could be corrected. This philosophy has endured until today and is still reflected in current physical examination standards.

Relaxation of dental health standards may have prevented a manpower problem during World War II, but it contributed to another problem. Prior to 1943, reports from the Southwest Pacific Area claimed that 80 percent of newly arriving troops needed dental care.³² Moreover, military postal service censors in North Africa reported to General Eisenhower that the most common complaint listed by soldiers in their letters home was the Army's failure to replace their missing teeth prior to deployment.³³

These problems convinced the Army to adopt strict deployment standards for soldiers scheduled to be shipped overseas. The standards were published in War Department Circular No. 189, which stated that "All necessary dental treatment, from a health and functional standpoint, will be provided troops prior to their departure from home station."³⁴ The newly established policy was aimed at unit commanders who had been reluctant to release soldiers from training to have dental work done. After the order was implemented, the shipment of personnel needing dental treatment ceased to be a major problem. In fact, the same Southwest Pacific Area that had previously complained about soldiers arriving in poor dental health, later reported that 85 percent of arriving personnel needed no dental treatment.³⁵

Korean War

A program to provide interceptive dental care was also put in place shortly after hostilities were initiated in Korea. Army dentists were able to complete much of the work needed by troops prior to deployment, but reports indicate that the overall results were unsatisfactory. Personnel arriving in the Korean theater frequently had to spend long periods in the dental chair in order to correct dental problems. A survey in 1952 revealed that 6.5 percent of the replacements in a field artillery battalion needed emergency dental treatment upon arrival, and another 43 percent required urgent treatment of advanced dental conditions.³⁶

According to Cowdrey, "...the Army's failure to survey and treat men adequately before shipping them overseas needlessly burdened the Far East Command."³⁷

A major problem contributing to this failure was the shortage of dentists in relation to the number of personnel needing treatment and the severity of their dental complaints. Another contributing factor was the same attitude that led to problems during World War II: unit commanders simply placed a higher priority on training requirements than on dental treatment for their troops.

Vietnam War

A similar situation arose during the Vietnam War. While visiting the theater in 1968, Major General Robert B. Shira, Chief of the Army Dental Corps, listened to complaints from field commanders that combat effectiveness was being disrupted by dental emergencies, some of which incapacitated men for as long as 7 days.³⁸ To address the problem, General Shira directed that a dental combat effectiveness program be established at all CONUS installations conducting advanced individual training.

The dental combat effectiveness program employed the same basic policies that had been successful in previous wars. An emphasis was placed on interceptive dental care - particularly for personnel with critical military occupational specialties. In addition, dental screening was instituted as part of the in-

processing for soldiers reporting to the replacement centers of combat units. Within 9 months after these programs were adopted, the annual dental emergency rate among Army personnel in Vietnam was reduced by almost 50 percent.³⁹

Post-Vietnam

Following the Vietnam War, the Army began to place a greater emphasis on the maintenance of dental health during peacetime. An interest in improving benefits for the all-volunteer force provided some of the impetus for this trend. Also contributing were a renewed interest in the lessons learned from past military conflicts, attention to the results of on-going dental health studies, and an increased emphasis on readiness. Guided by the Dental Corps, Army leaders at all levels gradually learned to appreciate the important relationship between sound dental health and overall readiness.

In recent years, the Army has published two regulations which further underscore its commitment to dental health. One regulation establishes the Oral Health Fitness Program which requires soldiers to maintain an acceptable level of dental health at all times. A key element of the Oral Health Fitness Program is a requirement for individual soldiers to report for dental examinations on an annual basis. Another important feature is a provision which makes unit commanders responsible for the dental fitness of their personnel. Commanders are required to refer any soldier for expedited

treatment whose dental classification is either 3 or 4.⁴⁰

The second regulation outlines the Soldier Readiness Program and includes dental requirements for soldiers readiness processing. Dental processing prior to deployment establishes a safety net for personnel who have not maintained an acceptable level of dental health so that they will not depart with dental problems. The Soldier Readiness Program requires unit commanders to refer personnel for dental treatment if, during processing for deployment, they are found to be in either Class 3 or Class 4.⁴¹

It is important to note that, although these regulations require the referral of soldiers in dental Class 3, they do not absolutely preclude soldiers from deploying in a Class 3 status. Recognizing the overriding importance of some military operations, regulations allow the first general officer in the chain of command to waive the requirement for dental referral. Moreover, soldiers who have been referred for dental care may ultimately deploy as Class 3s if there is insufficient time to complete their treatment. Only the most severe cases are kept from deploying with their units.

Unlike the Soldier Readiness Program which applies equally to active and reserve personnel, the Oral Health Fitness Program is not normally enforced for Reserve and National Guard members. They are not required to report for annual dental examinations and, in fact, they are not even authorized routine dental care in Army facilities. Once mobilized, however, Reserve Component personnel

are subject to the same standards for dental health as are active duty soldiers. This includes the requirement for referral of soldiers found to be in dental Class 3 and Class 4.

Desert Shield/Storm

Data on dental emergency rates in the Persian Gulf theater have not been analyzed. However, unofficial reports suggest that, early in the build up of American forces, dental complaints among Army personnel were not a significant problem.⁴² A major reason for this result is because very few soldiers were allowed to report to the theater in a dental Class 3 status. Requirements established by the Soldier Readiness Program gave Army dentists an opportunity to provide interceptive dental care prior to deployment. Of the over 33,000 Reserve and National Guard personnel who reported to mobilization sites in Class 3, 87 percent were converted to an acceptable level of dental health (Class 1 or 2) prior to mobilization.⁴³

REVIEW OF THE PROBLEM

Results from Operation Desert Shield/Storm suggest that, overall, the dental management of Reserve Component dental problems was largely a success. Soldiers in dental Class 3 were identified and, in the majority of cases, they were treated to acceptable levels of dental health prior to deployment. The Army Deputy Chief

of Staff for Personnel (DCSPER), has acknowledged that dental problems encountered during mobilization and deployment of Reserve Component soldiers did not constitute a "war stopper".⁴⁴ Yet, the Army DCSPER has also been an advocate for some program to improve the dental health status of Reserve Component soldiers.

One reason the DCSPER and other Army officials remain concerned is because the successful management of dental health problems came at the expense of a very valuable and limited resource - time. Reports from one site involved in the dental processing of Reserve and National Guard personnel claimed an average treatment time of 62 minutes for each Class 3 soldier.⁴⁵ And this did not include the total time invested for each patient. Allowing additional time for travel to and from the dental clinic, and time for administrative processing, patient waiting, and patient recovery, it can be seen that soldiers with dental problems were lost from their units for substantial periods. This is time that they were not able to spend on training and other critical deployment requirements. It is also time that may not be available during the next mobilization. Many Reserve and National Guard units were able to languish at mobilization sites due to extended deployment schedules. Without this extended time, a greater number may have had to be deployed in dental Class 3.

So, although the dental health of Reserve Component personnel may not have disrupted operations in the Persian Gulf, it did interfere with processing and training at CONUS mobilization sites.

Moreover, it could present an even greater problem in the future if deployment schedules need to be accelerated. Therefore, dental health in Army Reserve and National Guard soldiers remains a major concern for the Army's leadership.

PROPOSED SOLUTIONS

The number of Reserve Component personnel to be retained in the Army's force structure and the role of selected units remains uncertain. What is certain, however, is that the Reserves and National Guard will continue to be vital to the nation's defense. Readiness of reserve forces, particularly for key units, may prove to be even more important than it has been in the past. The Army was fortunate during mobilization for Operation Desert Shield/Storm that sufficient time was available to treat most dental problems seen in Reserve and National Guard soldiers. If this time is unavailable in the future, some program to ensure the dental fitness of Reserve Component personnel will need to be adopted.

With this in mind, possible solutions have been proposed, two of which have been endorsed as viable options. The discussion below will focus on these two possibilities and contrast them to a third alternative - maintain the status quo.

Self-Funded Dental Insurance

Even before the Persian Gulf War had ended, the Army DCSPER

proposed a low-cost dental insurance program for reserve members. This idea was later seized upon by the House Armed Services Committee which directed the Secretary of Defense to "...conduct a study to determine the feasibility and viability of a self-funded (no cost to the government) medical and dental insurance plan for the reserve components."⁴⁶

In evaluating this proposal (or any plan), to solve the Reserve Component dental health problem, only one question should be considered. That is, will it significantly reduce the number of Reserve and Guard soldiers in dental Class 3? In the case of a non-compulsory, self-funded, dental insurance plan, the answer will depend on two closely related factors - the cost and the participation rate.

Specific details for a dental insurance program have not been determined, but planners expect that the cost will be a minimum of twenty dollars each month.⁴⁷ As reasonable as this amount may seem, it still represents a sizeable sum for many lower enlisted members. It is also a relatively large sum compared to the average cost of employer-sponsored plans. According to data compiled by the Bureau of Labor Statistics in 1986, the majority of full-time employees in medium and large firms received dental coverage paid for entirely by their employers.⁴⁸ For those who were asked to contribute a share of the basic cost, the average amount for individual coverage was only three dollars per month.⁴⁹ If the cost of coverage seems unreasonable to personnel in the lower pay

grades, they may elect to decline participation in the plan. This would be unfortunate because, as a group, lower enlisted members have the most serious dental health problems.

Even if the basic cost for a dental insurance program can be made affordable, it may still have little impact on the number of soldiers in dental Class 3. Improvement in dental health will also depend on the copayment charged for dental services. The significance of this relationship was demonstrated in a Rand study conducted for the Department of Health and Human Services. Rand found that the greatest improvement in dental health was observed, not when a dental insurance plan was made available, but when the level of cost sharing was reduced.⁵⁰ Apparently, even for individuals enrolled in dental insurance plans, needed treatment may be declined if the out-of-pocket expense seems too great.

Care in Uniformed Facilities

The remedy favored by the three services' Dental Chiefs is to make care available through the federal direct care system.⁵¹ This would entitle Reserve and National Guard personnel to receive treatment from any of the uniformed services' wide network of clinical facilities. Adoption of this proposal requires more than just a change of policy, however. It would also require a change to the law. Currently, Reserve Component personnel are prohibited from receiving routine dental care in uniformed facilities.⁵²

Critics of this proposal argue that the additional resource

requirements would be too great - an unacceptable situation during a time of deep budget and personnel reductions. Moreover, it would be an unequal benefit because federal treatment facilities are not convenient to many Reserve and National Guard members. Finally, there is also a concern among some interested parties that other eligible beneficiaries would be crowded out of the direct care system.

As a compromise position, some officials have suggested that restrictions could be placed on the level of care provided to Reserve Component personnel in federal facilities. For example, Reserve and Guard soldiers could be limited only to periodic screening examinations or treatment of their Class 3 conditions. As another control, priority of care could be given to units specifically identified by the services for rapid deployment.⁵³

Status Quo

Advocates for maintaining the status quo argue that the problem was managed successfully during Operation Desert Shield/Storm, so there is no need to adopt untested and potentially expensive alternatives. However, as has already been pointed out, management of the problem cost the Reserves and National Guard a considerable amount of time. Moreover, it did not happen by accident.

Early on, planners at the Army's Health Services Command and Office of The Surgeon General recognized that a potential

mobilization problem could result from the poor dental health status of Reserve Component personnel. Utilizing information available from updated dental health studies, they predicted that 23 percent of Reserve and Guard soldiers would report in dental Class 3.⁵⁴ When the mobilization was ordered, dental units in the reserve structure were activated to help manage the increased workload, essential items of major equipment were purchased and placed at key sites, and operating hours were extended at Army dental clinics.

This planning process can be employed again to manage the workload associated with future mobilization requirements. However, to achieve the same result, sufficient personnel and facilities will need to be available to ensure a comparable surge capability. In addition, periodic monitoring of the dental health status of Reserve Component personnel will be necessary to provide the up-to-date information needed for proper planning.

SUMMARY AND RECOMMENDATIONS

As the Army moves toward a more austere force structure in the future, readiness and rapid deployment will become increasingly more important. Every soldier will be a critical asset, and the unnecessary loss of personnel because of dental complaints may present an even greater obstacle to mission accomplishment than it has in the past. For these reasons, the dental health of Reserve

Component personnel has been a cause of considerable concern for Army leaders.

The Army's Dental Health Care System was able to effectively manage the problem during mobilization for Operation Desert Shield/Storm. But to accomplish this task, many Reserve and National Guard soldiers had to spend a significant amount of time undergoing dental treatment. This is time that could have been put to better use, and it is time that may not be available when the next mobilization is ordered.

Efforts by the Army and DoD to seek a solution to the problem have focused on a way to make dental care available prior to mobilization. One of the proposals under consideration is for DoD to sponsor a self-funded, low-cost, dental insurance plan. While this would be a welcome benefit for some Reserve Component personnel, and some improvement in dental health would probably be evident, it is unlikely to result in a wholly satisfactory solution to the problem. For reasons already discussed, many Reserve and Guard members may not be able to afford even a low-cost dental insurance plan.

If the Army and DoD are truly serious about improving dental readiness in the Reserve Components, they should begin by holding reserve members to the same standards as apply to the active force. The Oral Health Fitness Program has proven to be effective in improving the dental readiness of active duty soldiers. Requirements outlined by this program should also be enforced for

Reserve and National Guard soldiers in the selected reserve. As an added measure (and as a show of good faith), DoD should also seek legislative change so that members of the reserve forces can gain access to uniformed dental facilities for the examination and treatment of Class 3 conditions.

Even if these policies are implemented, however, the Army should anticipate that many Reserve Component soldiers will continue to report in Dental Class 3 when mobilized. Compliance with requirements of the Oral Health Maintenance Program will be difficult to enforce and, as was previously pointed out, not all soldiers will be able to take advantage of care available in uniformed treatment facilities. For these reasons, the Army should also continue to monitor the dental health status of Reserve Component personnel and to plan resource requirements for mobilization. A surge capability will still be necessary to meet the dental treatment needs of many Reserve and National Guard soldiers.

ADDENDUM

This report was limited to a discussion of dental health in Army Reserve and National Guard soldiers for three primary reasons: 1) the problem was originally identified by the Army; 2) the Army was the service most intensely scrutinized and queried about the problem during Operation Desert Shield/Storm; and 3) extensive documentation and background information was readily available from the Army. But it is not a problem unique to the Army - a fact since acknowledged by Dr. Enrique Mendez, the Assistant Secretary of Defense for Health Affairs. In a letter to the Chairman of the Reserve Forces Policy Board, Dr. Mendez stated "...that significant numbers of Reserve and Guard members [from all branches of the military] recalled in support of Operation Desert Shield and Storm were found to be in poor dental health and that this had an adverse impact on their readiness capability."⁵⁵ The Assistant Secretary for Health Affairs also acknowledged that solutions to the problem must be jointly pursued and must apply to all the Reserve Components.

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